

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4503	(X2) MULTIPLE CONSTRUCTION A. BUILDING 77 - LICENSE B. WING _____		(X3) DATE SURVEY COMPLETED 02/07/2011
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF JEFFERSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the survey conducted on February 7, 2011, no licensure deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 002			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

James B. Henderson, E.D.
LND621

2/21/11

If continuation sheet 1 of 1